DENTAL BOARD OF CALIFORNIA
1432 HOWE AVENUE, SUITE 85, SACRAMENTO, CA 95825-3241
TELEPHONE: (916) 263-2300
FAX: (916) 263-2140

OUT-OF-STATE DENTAL LICENSURE CERTIFICATION

Submit this completed form (certified within the last six months) with your application.

TO BE COMPLETED BY APPLICANT (Please type or print)

1. **NAME**: Last: First: Middle:

2. **ADDRESS** (Number & street/rural route/apt no.)

City: State: Zip: Country:

3. **DATE OF BIRTH** (Mo/Day/Yr)	4. **GENDER**: Male ☐ Female ☐	5. **LICENSING AGENCY:**

TO BE COMPLETED BY LICENSING AGENCY:

I certify that _____ who graduated from
Name of Applicant

_____ on _____ was granted
Name of Dental School Date of Graduation

license number _____ on _____ in the state/country of _____
Date Issued

on the basis of _____.
Reciprocity/Credentialing/National Board/Licensing Agency Exam

I certify that this license is currently in good standing and that no disciplinary action is pending or has ever been taken against said license

NOTE: If any portion of the above certification is deleted or modified, please attach an explanation

_____ _____
Type or Print Name & Title of Agency Official Name of Licensing Agency

(SEAL)

_____ _____
Signature of Agency Official Address

Dated: _____ _____
City/State/Zip

_____
Telephone Number